Fayette County
Overnight Registration Form

NAME:_____

ADDRESS:_____

_____

(CITY) **(COUNTY)** **(STATE)** **(ZIP)**

Please check one of the following: I live in the following area:

☐ Fayetteville ☐ Unincorporated Fayette County ☐ PTC ☐ Town of Tyrone

☐ Town of Brooks ☐ Town of Woolsey ☐ Another County

PHONE:_____

(HOME) **(EMERGENCY)**

BADGE NAME:_____

TYPE OF ROOM ACCOMODATIONS: **_____Smoking** **_____Non-smoking**

_____Double Room **_____Single Room**

ROOMMATE NAME:_____

The undersigned participant or guardian acknowledges that participation is voluntary and agrees to waive and release any and all rights and claims for damages against the Fayette County Board of Commission and all employees and members of the same, for any claim arising out of any injury or damages to myself. By signing this release, I/ the guardian consent to such participation and also verify that adequate medical insurance is in effect during this period. In the event of an emergency and I cannot be reached, I give permission for authorities of the above name agency to seek immediate medical attention for myself.

This_____Day of _____2010

Signature_____

_____

Please print your name clearly

Mail check or money order to: Fayette County Parks & Recreation Department
140 West Stonewall Avenue
Fayetteville, Georgia 30214

Complete medical history on the reverse side of this form.

Fayette County
Participant Personal Information

NAME:_____

AGE:_____DATE OF BIRTH_____PHONE_____

EMERGENCY CONTACT_____

_____
(PHONE) (RELATIONSHIP)

PHYSICIAN NAME_____PHONE_____

LIST THE NAME OF YOUR MAJOR MEDICAL HEALTH INSURANCE COMPANY AND THE POLICY NUMBER:

_____
(INSURANCE COMPANY) (POLICY #)

LIST ANY KNOWN ALLERGIES OR MEDICAL PROBLEMS:_____

Do you currently have a history of:	Yes	No
Diabetes	☐	☐
High Blood Pressure	☐	☐
Back Problems	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Heart Problems	☐	☐
Pacemaker	☐	☐

Other_____

List any medications with time and dosage:_____

_____

Adverse reactions if medications are not taken as prescribed:_____

_____

Do you need a modification due to disability to enjoy this program? Check one: ☐ Yes ☐ No

In case of emergency, I give my permission for a Recreation Department representative to collect my belongings and seek immediate medical attention for myself. I have read and agree to all of the above.

_____
(Signature) (Date)